

**Trauma Responsive Practice with Children**

Bega Valley  
Paediatric Allied Health Team  
2021

Trainer: Karyn Robinson



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The Australian Childhood Foundation acknowledges Aboriginal and Torres Strait Islander people as the traditional custodians of this land and we pay our respect to their Elders past, present and future.



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**Safety**

The content of this training can evoke strong emotions and may trigger personal experiences of trauma.

Please be mindful of your own wellbeing during this training and if you need support please ask the facilitator.

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### Session Outline

**Explore:**

- Impacts of abuse-related trauma on early brain development, physiology and functioning
- Principles of Trauma-Responsive Practice with children
- Trauma-Responsive Strategies for working with infants, children and their parents/carers

**Experience:**

- Reparative interventions for infants & children

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### Principles underpinning this workshop

- While the focus of this session is on the child and their experience, there is a clear acknowledgement that engaging families and caregivers is critical in any intervention
- Understanding trauma and its impacts supports the capacity for effective intervention
- Abuse related trauma covers the impact of all forms of child abuse, including sexual abuse, physical abuse, emotional abuse, family violence and neglect

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**Trauma:**

- Definition
- Brain development impacts
- Physiology Impacts
- Arousal Regulation
- Relationships



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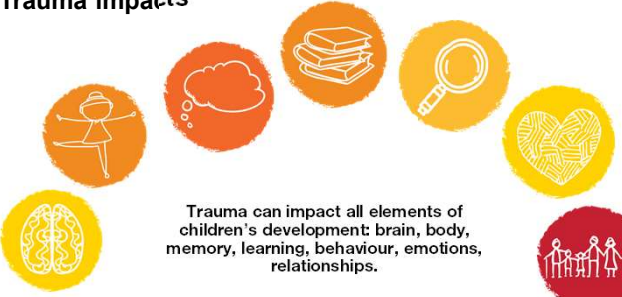
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**Trauma impacts**



Trauma can impact all elements of children's development: brain, body, memory, learning, behaviour, emotions, relationships.

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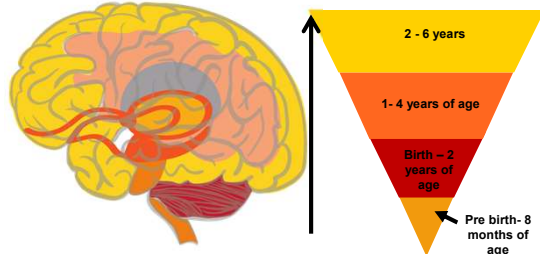
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**Developmental stages of brain maturation**



2 - 6 years

1- 4 years of age

Birth - 2 years of age

Pre birth- 8 months of age

Image source: ©2018 ACF

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### Trauma and the Brain

**Hypothalamus**  
Links the nervous system to the endocrine system via the pituitary gland. It synthesizes and secretes hormones to control body temperature, hunger, thirst, fatigue, sleep, and circadian cycles.

**Prefrontal cortex**  
Responsible for executive functions, such as judgement, reasoning, and self awareness. Final part of the brain to mature in one's mid 20s.

**Amygdala**  
Survival response centre within the limbic lobe that becomes enlarged and more sensitive the more it is activated through responding to threats

**Hippocampus**  
Consolidates memory by providing the context/ sequential data for episodic memories. Goes offline if trauma overwhelms and disrupts cortex.

**Corpus Callosum**  
Bridge between the 2 hemispheres. Chronic stress can damage and thin down this bundle of neurons

**Thalamus**  
Sensory receptor within the diencephalon. Receives and passes on sensory data to be further processed by other areas of the brain

**Cerebellum**  
Balance and coordination, motor skills may be impacted by trauma

Image source: AACF 2020

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### Trauma-consistent presentations

- Poor sensory integration – hyper or hypo-sensitivities to one or more sensory inputs (thalamus)
- Coordination or gross motor difficulties (cerebellum)
- Weight or growth concerns, appetite issues, teething delays, sleep issues (hypothalamus)
- Executive function difficulties; impulse control, problem solving, paying attention (prefrontal cortex)
- Difficulty naming and regulating emotions (corpus callosum, L-R integration)

**Discuss**

**What do you often see as 'reason for referral' in your health settings?  
How does a trauma-lens help you understand these presentations?**

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### Trauma-Responsive Principles

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### Understanding of neurobiology of trauma & child development

- Application of the theory into practice
- **How do you understand what's happening in the child's brain** and how will that influence your practice? i.e: *behaviour is an unmet need so how will your intervention address that unmet need rather than focussing solely on the behaviour?*
- **How do you understand the child's developmental age versus their chronological age?** How will this inform your decision-making around support and intervention for the child and the family?
- Parental brain development – given parents likely trauma history, what is happening in their brain and **how will this influence your engagement with them?**

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### Safety

- Polyvagal theory – biological safety, **child's perception of safety**
- Human safety – **are the people around me safe?**
- Environmental – **Is the environment conducive to the perception of safety?** Sensory input – smells, sights, sounds, etc.
- Organisational safety - does my organisation promote policies and practices that ensure safety of clients and staff?
- Consider child's internal world versus the external world
- Parents own trauma history and perception of safety – how will this impact on your ability to engage with them?

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### Cultural understanding

- **Child's sense of identity, belonging?** How is that supported/promoted?
- **Parents history, identity, parenting practices, style?** Where does it come from? How do we work with this?
- Cultural awareness/humility? What does this look like in my practice?
- Cultural competence, accessibility? Programs tailored to meet cultural needs?
- Diversity - **Who has a voice in this space?**

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### Therapeutic relationships

- **Child experiences safe, attuned, consistent relationship/s.** What does this look like?
- **Worker-parent relationship** – minimising re-traumatisation, co-regulating.
- Respected, **supported work relationships**
- Program requirements enable relationship building
- **Practice frameworks** that promote therapeutic relationships – DDP, sanctuary model

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### Self determination

- Child centred practice – **child's voice is heard and acknowledged**
- How is the **parent's experience understood** and acknowledged?
- How do you address **power imbalance** in your role?
- **How does the child/parent participate** in the program or care team/ referral process?

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## Hope based recovery

- **How does the child understand their future** and the possibilities available to them? (more appropriate for older children). What words do they use to describe themselves? How do they understand their condition or diagnosis?
- **How do parents understand the child's strengths**, as well as their own? How do they see their role in the child's intervention and plan?
- **How do you as a worker maintain hope** in complex trauma based work?

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## Self care



The best way to help the extremely dysregulated child, is to remain calm and regulated yourself.

**What works for you?**

- **How is self care promoted** to the child and the parent?
- Worker's understanding of **vicarious trauma** and its impacts
- Worker's **self care plan**
- How does the organisation support **worker wellbeing and self care to minimise VT?**

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## The Neurobiology of Safety

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**Protective Response can present as:**


**Mobilised Responses**  
*(fight, flight, active freeze):*

- Hypervigilant
- Edgy/jumpy
- Irritable – easily annoyed
- Poor recovery from distraction
- 'silly', loud, over-excitement
- Unsettled, restless
- Outbursts, aggression
- Defensive, taking things personally
- Inflexible, 'controlling'
- Sensitive to sensory input

**Immobilised Responses**  
*(collapse, withdraw, dissociate):*

- Flat, numb affect
- Disengaged, disinterested
- Withdrawn
- Frequent "boredom"
- Lethargic, unmotivated
- Disconnected from peers
- Primitive self-soothing
- Hygiene issues
- Wetting or soiling
- Low appetite

Discuss 


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## Safety In Relationships


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**Relationships**

- Through relationships with important attachment figures, **children learn to trust others, regulate their emotions, and interact with the world;** they develop a sense of the world as safe or unsafe, and come to understand their own value as individuals.
- **When those relationships are unstable or unpredictable, children learn that they cannot rely on others to help them.** When primary caregivers exploit and abuse a child, the child learns that he or she is bad and the world is a terrible place.
- The majority of abused or neglected children have difficulty developing a strong healthy attachment to a caregiver. **Children who do not have healthy attachments have been shown to be more vulnerable to stress.** *(The National Child Traumatic Stress Network)*


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### Attachment and Regulation

Attachment Theory is now being described as the

## Theory of REGULATION

(Alan Schore, 2014, ACF Trauma Conference)

**Secure Attachment**

*Appraising the infant's feeling state; regulating/transforming it into something tolerable, and communicating it back to the infant.*

This requires primary caregivers to regulate their own high or very low levels of arousal




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### Serve and Return



[https://youtu.be/m\\_5u8-QSh6A](https://youtu.be/m_5u8-QSh6A)




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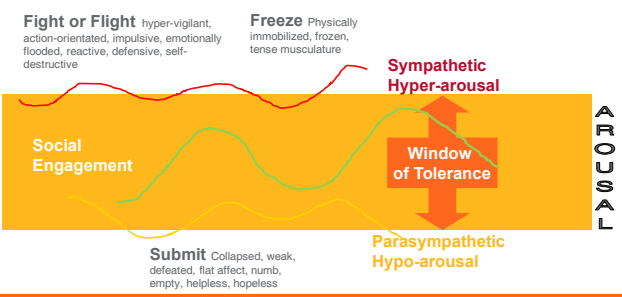
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### Review - Regulated & Dysregulated Arousal

Ogden, Minton, Pain 2006



**Fight or Flight** hyper-vigilant, action-orientated, impulsive, emotionally flooded, reactive, defensive, self-destructive

**Freeze** Physically immobilized, frozen, tense musculature


**Sympathetic Hyper-arousal**

**Window of Tolerance**

**Parasympathetic Hypo-arousal**

**Submit** Collapsed, weak, defeated, flat affect, numb, empty, helpless, hopeless

**Social Engagement**



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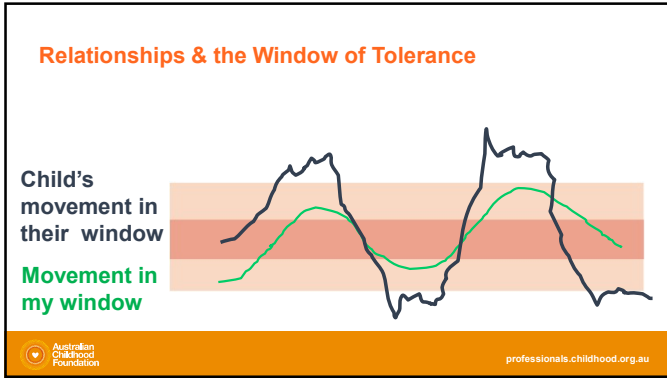
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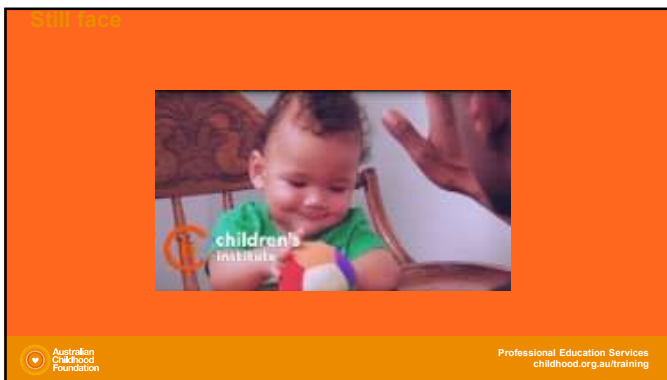
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- ### Why is regulation so important?
- Facilitates cortical functioning
  - Enables integration of sensory data
  - Promotes awareness of Neuroception
  - Holds attention to the here and now, rather than pulling it to the past
  - Reinforces co-regulation as foundational and necessary
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## Trauma Responsive Strategies

- Understanding Behaviour
- Strengthening the Child's Key Relationships
- Creating Felt Safety
- Working With Protective Responses

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## Trauma responsive strategies need a cultural lens.

- Can I understand the behaviour through a cultural lens?
- How does culture influence the shape of the relationship?
- How does culture help guide me in creating safety?
- How does cultural humility help me improve my understanding and build trust?

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## Understanding behaviour

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### Understanding Behaviour

Understanding the meaning, function & origin behind challenging external presentations is key in developing effective responses

**For children with complex trauma, we cannot rely on consequences/punishment to promote positive behaviour change**



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### Activity - Understanding Behaviour

1. Behaviour = unmet need
2. Developmental stage of the child?
3. Current state of the child's nervous system? (What we know about the neurobiology of trauma)
4. Survival/protective response – fight, flight, freeze, dissociate
5. Coping strategy (that no longer works)
6. Structural changes in the brain
7. How is this problem the child's solution?
8. Trauma induced thinking and conditioning

[www.echoparenting.org](http://www.echoparenting.org)

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### Activity - Understanding Behaviour

ACTIVITY:  
Read through the following 'presenting concerns' and consider how you might understand that behaviour:

- Child complains of abdominal pain in mornings – no organic cause determined
- Child is inattentive and restless
- Carers report emotional outbursts and aggression that seem 'out of the blue'
- 10 week old baby in care since 2 weeks, reported to be 'good baby' – never cries, does not wake for night feeds, poor weight gain
- 8yr old child soils during the day

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## Strengthening the child's key relationships



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### Relationship based strategies

- Safe, enriching, positive relationships with others and the broader community
- Connection to at least one safe adult in their world
- Knowing the child - their history, triggers, needs, desires
- Understand the child's chronological age as well as their developmental age
- Look for opportunities for repair – time in



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### Relationship based strategies

**For very young children:**

- Maintaining eye contact
- Physical touch – holding, rocking, patting, sitting near them
- Mirroring responses – smiling, cooing, singing, talking
- Engaging them in play, floor time
- Holding infants whilst bottle feeding
- Shared focus – point to something and interest



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### Relationship based strategies

For school age children, support parents to:

- Be curious and 'wonder about' their child's behaviours
- View discipline as a learning not a punishment (how can we put this right?)
- Take delight in their child and belly laugh with them
- Notice what the child does well and offer praise
- Set boundaries and have good routines
- Use 'time in' rather than time out



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### Parents/carers

**A powerful predictor of secure attachment in children, is coherent self-narrative in parents.** (Fonagy)

- A parent's reflective awareness is regulating and containing for the infant- and also for the parent
- Interventions which enhance parental reflective functioning, can help parents make sense of mental states and help children to feel understood
- Role model 'speaking for the infant' (or child)

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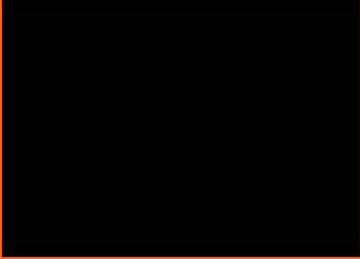
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### RACE – Reflective, Accepting, Curious, Empathic



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**Connection before correction – Kim Golding**

- Research shows that **we cannot influence children in a positive way until we create a connection with them.**
- **Connection creates a sense of safety and openness.** Punishment, lecturing, nagging, scolding, blaming or shaming create fight, flight, or freeze.
- **Validation of intense emotions** – mirroring, serve and return, naming emotions
- Body language, facial expression, tone of voice
- **Correction is about finding a solution with the child rather than imposing a punishment**

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**Activity: Scripting responses to strengthen relationship**

Using the concepts of P.A.C.E., naming emotions, speaking as the child, repairing after rupture, validating etc; script as many phrases as you can that could be modelled by you and/ or used by the parent/ carer i.e.

“Oh no! Look mummy, I tripped over and broke my toy. I’m sorry. I’m really sad. Can I have one your special mum hugs?”

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**Two hands for parenting – Kim Golding**

**Hand One: provides warmth and nurture, and allows:**

- Child appropriate autonomy matched to their developmental age.

**Hand Two: provides structure, and boundaries:**

- Connection before correction
- No correction without understanding
- Avoid lectures and delay problem solving
- Avoid punishing with the relationship
- Adult takes responsibility for relationship repair



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Anticipate child's **N**needs

- U**nconditional positive regard
- R**eframe child's perceptions
- T**ime-in
- U**se words for child's experience
- R**eflect back child's feelings
- E**njoy play together



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### Activity

What does strengthening relationships look like in your role?



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### Creating felt safety



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### Creating (Felt) Safety

**Key messages:**


- Cues of threat and safety are continually monitored by our nervous system
- Cues of threat or safety can be found in experiences, relationships, and environments
- Change and uncertainty are interpreted by the brain as threats
- Before we can engage in social behaviour and learning, we must feel safe

**Practice Implications:**

- Proximity, prosody, facial expression and body language can all provide cues of safety
- Predictability, consistency, familiarity and routine are critical in creating 'felt safety'
- No matter the treatment goal, SAFETY is always priority
- Environmental audits are important – consider the types and levels of sensory input from a child's perspective (in clinic, home & school settings)

**Examples:**

- Get down low and use modulated, calm voice and face
- Reduce unnecessary sensory stimuli
- Provide visual cues, diagrams & reminders
- Incorporate familiarity and consistency wherever possible (appointment times, rooms, clinicians)



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### Activity

What does encouraging a felt sense of safety in parent/ carer and child look like in your role/ team?

What does it look like for staff members within your organisation?



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### Working with protective responses



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### Working with Protective Responses

**Calm the brain with:**


- Long outbreaths
- Mindful activities
- Orienting outwards
- Connection & Co-regulation
- "Name it to tame it"

**De-activate Mobilised Responses with:**

- Rhythm (drumming, music, swinging, rocking, bouncing)
- Stretching/Yoga
- Push against wall/cushion
- Carrying heavy items
- Heat pack, weighted blanket
- Reduce stimulation
- Hugging a teddy/cushion

**Counter Immobilised Responses with:**

- Grounding through the senses (shoes off feel the floor)
- Proprioceptive input
- Fan/ splash cold on the face
- Something cold or sweet to drink/ suck icecube
- Chewing candies/sucking a mint/lollipop
- Balance toy on head



SMART  
Strategies for Managing Abuse Related Trauma

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### Body percussion – Making a thunderstorm





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### Working with protective responses in parents/ carers

- What does this look like? Discuss possible approaches and strategies to help parents/ carers maintain or regain their social engagement responses.



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### Key points

- Trauma impacts the biological structures of developing brain and body – the brain adapts to its experiences
- Complex trauma occurs in the context of relationships and heals in the context of relationships
- Safety, predictability and repetition are key
- Helping the parents to regulate themselves will help them to regulate their children
- Strategies must support both hyper-arousal and hypo-arousal states to help the child return to their window of tolerance or social engagement
- Self care is essential for parents and workers in order to support children experiencing trauma

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